Los Angeles County Area Agency on Aging

Agency Name: _____ Fiscal Year: _____

UNIVERSAL INTAKE FORM

Funding Identifier:

Title III B ☐ C1 ☐ C2 ☐ Title III D ☐ Title III E ☐ Title III E(G) ☐ Linkages ☐ SNAP-Ed ☐

CLIENT DEMOGRAPHICS

1	Applicant Last Name	First Name	Middle Initial	Client ID #

Home Address *(Number/Street)*	City	State	Zip Code

Home Phone	Work Phone	Cell Phone

Date of Birth (D.O.B.)	Age	Gender	Transgender
		☐ Male ☐ Female ☐ Declined to State	☐ Yes ☐ No

Mailing Address *(If different than home address)*	City	State	Zip Code

Email Address

Veteran ☐ Yes ☐ No	Spouse of Veteran ☐ Yes ☐ No	Veteran #

Client Race

☐ White ☐ American Indian or Alaska Native ☐ Chinese ☐ Japanese ☐ Filipino ☐ Korean ☐ Vietnamese

☐ Asian Indian ☐ Laotian ☐ Cambodian ☐ Other Asian ☐ Black or African American ☐ Guamanian

☐ Hawaiian ☐ Samoan ☐ Other Pacific Islander ☐ Other Race ☐ Multiple Race ☐ Declined to State

Client Ethnicity ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined to State

Relationship Status ☐ Single (Never Married) ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Declined to State

Type of Residence	Does the individual (*Optional*)
☐ House ☐ Apartment ☐ Hotel ☐ Mobile Home ☐ Nursing Home ☐ Residential Care Home ☐ Room and Board ☐ Homeless ☐ Other	☐ Rent ☐ Own ☐ Other

Living Arrangement	Rural Designation	Unincorporated City
☐ Lives alone without help ☐ Lives with others without help ☐ Lives alone with help 4 hrs/day or less ☐ Lives with others with help ☐ Declined to State	☐ Rural ☐ Urban ☐ Declined to State	☐ Yes ☐ No

Primary Language Spoken

☐ American Sign Language ☐ Arabic ☐ Armenian ☐ Cambodian ☐ Cantonese ☐ Chinese ☐ English

☐ Farsi ☐ French ☐ Korean ☐ Laotian ☐ Mandarin ☐ Japanese ☐ Russian ☐ Spanish ☐ Tagalog

☐ Thai ☐ Vietnamese ☐ Other

Translation needed ☐ Yes ☐ No

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EMERGENCY CONTACT

2

Contact Last Name	First Name	Middle Initial
Address *(Number/Street)*	City	State / Zip Code
Home Phone / Work Phone	Cell Phone	Relationship
Contact Name (*Last, First, Middle Initial*) – *Optional*		
Address *(Number/Street)*	City	State / Zip Code
Home Phone / Work Phone	Cell Phone	Relationship
Physician's Name		Office Phone
Physician's Address	City	State / Zip Code

FINANCIAL/BENEFITS

3

Are you currently receiving Social Security Benefits? ☐ Yes ☐ No	What benefit(s) are you receiving?	Social Security # (*Optional*)
Do you currently receive SSI benefits? ☐ Yes ☐ No	Do you participate in CalFresh (Food Stamps, SNAP, EBT)? ☐ Yes ☐ No	
Do you have Health Insurance? ☐ Yes ☐ No	Health Insurer's Name	Policy Number: *(Optional)*
Do you receive Medi-Cal? ☐ Yes ☐ No	Medi-Cal # *(Optional)* Issue date:	Do you receive Medicare? ☐ Yes ☐ No

Do you receive In-Home Supportive Services *(IHSS)?* ☐ Yes ☐ No

Is your personal income at or below Federal Poverty Level? ☐ Yes ☐ No ☐ Declined to State

Employment Status *(Check One)*

☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Declined to State

REFERRAL INFORMATION

4

Referral Source	Referral Source relationship to client
Last Name / First Name	Phone
Address / City	State / Zip Code

Interview Mode ☐ Face-to-Face (*Appointment*) ☐ Telephone ☐ Drop-In ☐ In-Home

Presenting Problems/Services Requested/Comments/Follow-up:

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NUTRITIONAL RISK FACTORS

5 NUTRITIONAL RISK

(Add the numbers from each checked box to determine Nutrition Risk Score)

I have an illness or condition that made me change the kind and/or amount of food I eat.	2 □ Yes	□ No	□ Declined to State
I eat fewer than 2 meals per day.	3 □ Yes	□ No	□ Declined to State
I eat few fruits or vegetables or milk products.	2 □ Yes	□ No	□ Declined to State
I have 3 or more drinks of beer, liquor or wine almost every day.	2 □ Yes	□ No	□ Declined to State
I have tooth or mouth problems that make it hard for me to eat.	2 □ Yes	□ No	□ Declined to State
I don't always have enough money to buy the food I need.	4 □ Yes	□ No	□ Declined to State
I eat alone most of the time.	1 □ Yes	□ No	□ Declined to State
I take 3 or more different prescribed or over-the-counter drugs a day.	1 □ Yes	□ No	□ Declined to State
Without wanting to, I have lost or gained 10 pounds in the last 6 months.	2 □ Yes	□ No	□ Declined to State
I am not always physically able to shop, cook and/or feed myself.	2 □ Yes	□ No	□ Declined to State
Total Nutritional Risk Score		(If total is 6 or more, participant is at **High** Nutritional Risk)	

ADL / IADL RISK FACTORS

6 ACTIVITIES OF DAILY LIVING (ADL) /INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)

Excluding Title III E Caregiver Program

Activities of Daily Living *(ADL)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Eating	□	□	□	□	□	□
Bathing	□	□	□	□	□	□
Toileting	□	□	□	□	□	□
Transferring	□	□	□	□	□	□
Walking	□	□	□	□	□	□
Dressing	□	□	□	□	□	□

Instrumental Activities of Daily Living *(IADL)*

	Independent	Verbal Assistance	Some Human Help	Lots of Human Help	Dependent	Declined to State
Meal Preparation	□	□	□	□	□	□
Shopping	□	□	□	□	□	□
Med. Mgmt.	□	□	□	□	□	□
Money Mgmt.	□	□	□	□	□	□
Using Phone	□	□	□	□	□	□
Hvy. Housework	□	□	□	□	□	□
Lt. Housework	□	□	□	□	□	□
Transportation	□	□	□	□	□	□

DISABILITY FACTORS

☐ Visually Impaired ☐ Hearing Impaired ☐ Speech Impaired

☐ Physically Impaired ☐ Walking Aid ☐ Wheelchair

☐ Bedbound ☐ Memory Impaired ☐ Depression

☐ Cognitively Impaired ☐ Declined to State ☐ None

Recent Hospital Discharge ☐Yes☐ No

Date of Discharge

Date To Stop Service

Hospital

Diabetic

☐ Yes ☐ No

Have you been diagnosed with Alzheimer's or a related neurological disorder?

☐ Yes ☐ No

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CERTIFICATION

CERTIFICATION	9	***CERTIFICATION*** *(To be completed by Interviewer and signed by Client)* *I certify that the information on this form, provided to me by the client, is accurate and true to the best of my abilities. I also certify that I have informed the Client that this information may be shared with other providers for the purpose of providing services. Client signature establishes agreement to services.*

Completed by (Print Name)	*Phone*
Signature	*Date*
Client Name (Print)	
Client Signature	*Date*

REASON FOR DEACTIVATION

10 REASON FOR DEACTIVATION

☐ Deceased ☐ Moved Out of Service Area ☐ No Longer Desires Services ☐ No Longer SNF Certifiable
☐ No Longer Medi-Cal Eligible ☐ Institutionalization ☐ High Cost of Services ☐ Won't Follow Care Plan
☐ On Hold ☐ Service No Longer Needed ☐ Past Active ☐ On Waiting List ☐ Other Reason

Notes:

Thank you for completing the Universal Intake Form (UIF). As the aging population grows and funding remains limited, it is vital to capture this critical information to reinforce and substantiate the increased demand for older adult services. This information will assist the Los Angeles County Area Agency on Aging (AAA) in identifying unmet needs, effectively developing plans, and better coordinating services to meet your needs.